# Billing

## What is the time limit for billing? [Refer to WAC 388-502-0150]

HRSA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. HRSA has two timeliness standards: 1) for initial claims; and 2) for resubmitted claims.

- The provider must submit claims as described in HRSA's billing instructions.

- HRSA requires providers to obtain an ICN for an **initial claim** within 365 days from any of the following:

  - ✓ The date the provider furnishes the service to the eligible client;
  - ✓ The date a final fair hearing decision is entered that impacts the particular claim;
  - ✓ The date a court orders HRSA to cover the services;
  - ✓ The date DSHS certifies a client eligible under delayed[1] certification criteria; or
  - ✓ The date an HRSA managed care plan or Basic Health Plus client's premium has been recouped by HRSA.

- HRSA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:

  - ✓ DSHS certification of a client for a retroactive[2] period; or
  - ✓ The provider proves to HRSA's satisfaction that there are other extenuating circumstances.

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[1] **Delayed Certification -** According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill HRSA for the service.

**Eligibility Established After Date of Service but Within the Same Month -** If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill HRSA for the service.

[2] **Retroactive Certification -** According to WAC 388-500-0005, retroactive period means the three calendar months before the month of application (month in which client applied). If, due to retroactive certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for any unpaid charges for the service; **and may refund** any payment already received from the client or anyone acting on the client's behalf, and after refunding the payment, the provider may bill HRSA for the service.

- Providers may **resubmit, modify, or adjust** any timely initial claim, *except* prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

> **Note:** HRSA does not accept any claim for resubmission, modification, or adjustment after the allotted time period listed above.

- The allotted time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to HRSA by claim adjustment. The provider must refund overpayments to HRSA by a negotiable financial instrument such as a bank check.

- The provider, or any agent of the provider, must not bill a client or a client's estate when:

  - ✓ The provider fails to meet these listed requirements; and
  - ✓ HRSA does not pay the claim.

# What fee must I bill HRSA?

Bill HRSA your usual and customary fee.

# How do I bill for multiple services?

If multiples of the same procedure are performed on the same day, providers must bill the appropriate modifier (if applicable) and must bill the services on the same claim form to be considered for payment.

# Third-Party Liability

Bill the insurance carrier(s) indicated on the client's DSHS Medical ID Card prior to sending the claim to HRSA. An insurance carrier's time limit for claim submissions may be different than HRSA's. It is your responsibility to meet HRSA's and the insurance carrier's requirements relating to billing time limits, prior to any payment by HRSA.

You must meet HRSA's 365-day billing time limit even if you have not received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding HRSA Remittance and Status Report (RA) for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by HRSA or if you have reason to believe that HRSA may make an additional payment:

- Submit a completed claim form to HRSA; or
- Attach the insurance carrier's statement.

Third-party carrier codes are available on the Internet at http://maa.dshs.wa.gov/LTPR, or by calling the Coordination of Benefits Section at 800.562.6136.

# Primary Care Case Management (PCCM) Clients

Clients who obtain care with a PCCM will have a "PCCM" identifier in the HMO column. These clients must obtain their services through the PCCM. The PCCM is responsible for coordination of care just like the PCP is in a plan setting. ***Please refer to the client's DSHS Medical ID card for the PCCM***. When billing HRSA, place the PCCM's provider number in the referring provider field.

**Note:** Newborns of clients who are connected with a PCCM are fee-for-service until a PCCM has been chosen for the newborn.

# How do I bill for clients eligible for Medicare and Medicaid?

If a client is eligible for both Medicare and Medicaid, **you must *first* submit a claim to Medicare and accept assignment within Medicare's time limitations.** HRSA may make an additional payment after Medicare pays you.

- If the Medicare EOMB shows Medicare has allowed any of the charges (whether applied to the copay or deductible) on the claim, the provider must bill HRSA within six months of the date Medicare processes the claims.
- If Medicare denies payment of the claim, HRSA requires the provider to meet HRSA's initial 365-day requirement for initial claims (see page M.1).

## Medicare Part A

Medicare Part A is a health insurance program for:

- Individuals who are 65 years of age and older;
- Certain individuals with disabilities (younger than 65 years of age); or
- Individuals with End-Stage Renal Disease (permanent kidney failure requiring dialysis or transplant).

Medicare Part A helps individuals pay for hospital stays, skilled nursing facilities, hospice and some home health care. Check the client's red, white and blue Medicare card for the words "Part A (hospital insurance)" in the lower left corner of the card to determine if the client has Medicare Part A coverage.

Under Part A, Medicare will pay its allowed charges, minus any deductible and/or coinsurance, when appropriate.

> Payment for services rendered to Qualified Medicare Beneficiaries (QMBs) is limited to the Medicare payment if the Medicare payment exceeds the amount HRSA would pay for the same service had the service been paid under the ratio of costs-to-charges (RCC) payment methodology (whether normally paid using the DRG or RCC methodologies).

**When billing Medicare:**

- Indicate *Medicaid* and include the patient identification code (PIC) on the claim form as shown on the client's DSHS Medical ID card. Enter the Medical Assistance provider number.

- Accept assignment.

- If Medicare has allowed the service, in most cases Medicare will forward the claim to HRSA. HRSA then processes the claim for any supplemental payments.

- If Medicare does not forward your claim to HRSA **within 30 days** from its statement date, send the UB-92 claim form and a copy of the Part A Explanation of Medical Benefits (EOMB) to HRSA for processing (see *Important Contacts* for address).

- When Part A services are totally disallowed by Medicare but are covered by HRSA, bill HRSA on the UB-92 claim form and attach copies of Medicare's EOMB with the denial reasons.

> **Note:**
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> ✓ Medicare/Medicaid billing claims must be received by HRSA within six (6) months of Medicare's EOMB paid date.
> ✓ A Medicare Remittance Notice or EOMB must be attached to each claim.

## Medicare Part B

Benefits covered under Part B include **physician, outpatient hospital, home health, durable medical equipment, and other medical services and supplies** not covered under Part A.

When the words *"This information is being sent to either a private insurer or Medicaid fiscal agent,"* appear on your Medicare remittance notice, it means that your claim has been forwarded to HRSA or a private insurer for deductible and/or coinsurance processing.

If you have received a payment or denial from Medicare, but it does not appear on the RA within 45 days from Medicare's statement date, bill HRSA directly.

- If Medicare has made payment, and there is a balance due from HRSA, you must submit a HCFA-1500 claim form. Bill only those lines Medicare paid. Do not submit paid lines with denied lines. This could cause a delay in payment.

- If Medicare denies the service, but HRSA covers it, bill HRSA on a HCFA-1500 claim form. Bill only those lines Medicare denied. Do not submit denied lines with paid lines. This could cause a delay in payment.

- If Medicare denies a service that requires prior authorization by HRSA, HRSA waives the ***prior*** authorization requirement. However, providers must obtain an authorization number from HRSA after the service has been performed (see Section I). Authorization or denial of your request will be based upon medical necessary.

**Note:**

- ✓ Medicare/Medicaid billing claims must be received by HRSA within six (6) months of Medicare's EOMB paid date.
- ✓ A Medicare Remittance Notice or EOMB must be attached to each claim.

### Payment Methodology – Part B

- MMIS compares HRSA's allowed amount to Medicare's allowed amount and selects the lesser of the two. (If there is no HRSA allowed amount, the departments's payments system uses Medicare's allowed amount.)

- Medicare's payment is deducted from the amount selected above.

- If there is *no* balance due, the claim is denied because Medicare's payment exceeds HRSA's allowable.

- If there *is* a balance due, payment is made towards the deductible and/or coinsurance up to HRSA's maximum allowable.

HRSA does not make direct payments to clients to cover the deductible and/or coinsurance amount of Medicare Part B. HRSA *may* pay these costs to the provider on behalf of the client when:

- The provider **accepts** assignment; and

- The total combined payment to the provider from Medicare and Medicaid does not exceed Medicare or Medicaid's allowed amount, whichever is less.

## Medicare Part C

Benefits covered under Medicare Part C include:

- Physician services;
- Outpatient hospital services;
- Home health;
- Durable medical equipment; and
- Other medical services and supplies not covered under Part A.

If a client is enrolled in a Managed Medicare - Medicare Advantage (Part C) plan submit the claim to the Managed Medicare - Medicare Advantage plan first. Managed Medicare - Medicare Advantage is the primary payer of claims.

After receiving payment or denial from the Managed Medicare - Medicare Advantage plan, submit the claim to HRSA. Indicate "Managed Medicare" as follows:

- HCFA/CMS 1500 in field 19; or
- Electronic billing in the on-line comments.

HRSA must receive claims within 6 months of the Managed Medicare – Medicare Advantage payment date and must include the Managed Medicare EOB to avoid delayed or denied payment due to late submission.

HRSA does not accept altered EOB's.

If the Managed Medicare - Medicare Advantage plan allows a service that requires PA by HRSA, HRSA waives the PA requirement.

> **Note:** Discrepancies, disputes, protests, or justifications for a higher fee or payment for any claim should be directed to your Managed Medicare - Medicare Advantage plan. If Managed Medicare - Medicare Advantage adjusts the payment and the claim has previously been paid, you may submit an adjustment request to HRSA. Submit a new claim if the original claim was denied.

## HRSA's Payment Methodology – Managed Medicare - Medicare Advantage (Part C) Plans

In order to receive payment from HRSA, it is necessary to follow the billing guidelines established from the Managed Medicare – Medicare Advantage plan prior to billing HRSA.

**If there is a co-payment due on a claim:**

- Bill HRSA the co-payment amount for each service or procedure.
- For non capitated co-payment claims ,which require that the Medicare EOB be attached to the claim, you must indicate "Managed Medicare" as follows:
  - ✓ HCFA/CMS 1500 in field 19; or
  - ✓ Electronic billing in the on-line comments.
- For capitated co-payments ,which do not require the biller to submit with an EOB, indicate "Managed Medicare capitated co-payment" and line item number as follows:
  - ✓ HCFA/CMS 1500 in field 19; or
  - ✓ Electronic billing in the on-line comments.
- Bill services using the appropriate level of coding.

**Note:** HRSA pays co-payments as indicated when there is a co-payment due for services rendered.

**If there is coinsurance or deductible due on a claim:**

- If there is a balance due:

  - ✓ Bill all services, paid or denied, to HRSA on one claim form, and attach an EOB.

  - ✓ Indicate "Managed Medicare as follows:

    - ➢ HCFA/CMS 1500 in field 19; or
    - ➢ Electronic billing in the on-line comments.

- HRSA will compare the allowed amount for HRSA and Managed Medicare – Medicare Advantage and select the lesser of the two.

- Payment is based on the lesser of the allowed amounts minus any prior payment made by Managed Medicare – Medicare Advantage.

- If there is no balance due, the claim will be denied.

**If there is coinsurance, deductible, and co-payment due on a claim:**

- Bill all on the same claim form. Bill the services to HRSA exactly as they appear on the Medicare advantage EOB

- Indicate "Managed Medicare" and line item number for the co-payment as follows:

  - ✓ HCFA/CMS 1500 in field 19; or
  - ✓ Electronic billing in the on-line comments.

- If the Medicare Advantage plan allows a service that normally requires PA by HRSA, HRSA will waive the PA requirement.

## QMB (Qualified Medicare Beneficiaries) Program Limitations:

**QMB with CNP or MNP (Qualified Medicare Beneficiaries with Categorically Needy Program or Medically Needy Program)**

(Clients who have CNP or MNP identifiers on their DSHS Medical ID card in addition to QMB)

- If Medicare ***and*** Medicaid cover the service, HRSA pays only the deductible and/or coinsurance up to Medicare or Medicaid's allowed amount, whichever is less.

- If only Medicare ***and not Medicaid*** covers the service, HRSA pays only the deductible and/or coinsurance up to Medicare's allowed amount.

- If only Medicaid ***and not Medicare*** covers the service, and the service is covered under the CNP or MNP program, HRSA pays for the service.

## QMB-Medicare Only

The payment criteria for this program are as follows:

- If Medicare ***and*** Medicaid cover the service, HRSA pays only the deductible and/or coinsurance up to Medicare or Medicaid's allowed amount, whichever is less.

- If only Medicare ***and not Medicaid*** covers the service, HRSA pays only the deductible and/or coinsurance up to Medicare's allowed amount.

**For QMB-Medicare Only:**
If **neither Medicare or Medicaid** covers the service,
HRSA does not pay providers for the service.

# What general records must be kept? [Refer to WAC 388-502-0020]

**Enrolled providers must:**

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Chief complaint or reason for each visit;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination;
  - ✓ Medications (including NDC numbers), equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ X-rays, tests, and results;
  - ✓ Plan of treatment and/or care, and outcome; and
  - ✓ Specific claims and payments received for services.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, ***for at least six years from the date of service*** or more if required by federal or state law or regulation.

**Note:** A provider may contact HRSA with questions regarding HRSA's programs. However, HRSA's response is based solely on the information provided to HRSA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern HRSA's programs.
(Refer to WAC 388-502-0020[2])

**See HRSA's program-specific billing instructions for information that may be necessary to keep in addition to those general records listed above.**